KANSAS STATE EMPLOYEE HEALTH PLAN

Annual Notice of Changes for 2014

You are currently enrolled as a member of Advantra Freedom (PPO), a Coventry Medicare Advantage plan. Next year, there will be some changes to the plan's costs and benefits*. This booklet tells about the changes.*

You may make a change during the annual enrollment period offered by your Employer Group, Union, or Benefit Trust.

Additional Resources

- Customer Service has free language interpreter services available for non-English speakers (phone numbers are in Section 7.1 of this booklet).
- This document may be available in Braille or large print.

About Coventry Medicare Advantage (PPO)

- Coventry Health and Life Insurance Company is a Coordinated Care plan with a Medicare contract. Enrollment in our plan depends on contract renewal.
- When this booklet says "we", "us", or "our", it means Coventry Health and Life Insurance Company. When it says "plan" or "our plan", it means Coventry Medicare Advantage (PPO).

KSEHP PPO (5509)

Think about Your Medicare Coverage for Next Year

Each fall, Medicare allows you to change your Medicare health and drug coverage during the Annual Enrollment Period. It's important to review your coverage now to make sure it will meet your needs next year.

Important things to do:

- ☐ **Check the changes to our benefits and costs to see if they affect you.** Do the changes affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. Look in Sections 1.5 and 1.6 for information about benefit and cost changes for our plan.
- ☐ **Check the changes to our prescription drug coverage to see if they affect you.** Will your drugs be covered? Are they in a different tier? Can you continue to use the same pharmacies? It is important to review the changes to make sure our drug coverage will work for you next year. Look in Section 1.6 for information about changes to our drug coverage.
- ☐ **Check to see if your doctors and other providers will be in our network next year.** Are your doctors in our network? What about the hospitals or other providers you use? Look in Section 1.3 for information about our Provider/Pharmacy Directory.
- ☐ **Think about your overall health care costs.** How much will you spend out-of-pocket for the services and prescription drugs you use regularly? How much will you spend on your premium? How do the total costs compare to other Medicare coverage options?
- ☐ **Think about whether you are happy with our plan.**

If you decide to <u>stay</u> with Kansas State Employee Health Plan:	**If you decide to <u>change</u> plans:**
If you want to stay with us next year, it's easy – you don't need to do anything. If you don't make a change by December 7, you will automatically stay enrolled in our plan.	If you decide other coverage will better meet your needs, you can switch plans between November 1 and November 30. If you enroll in a new plan, your new coverage will begin on January 1, 2014. Look in Section 3.2 to learn more about your choices.

Summary of Important Costs for 2014

The table below compares the 2013 costs and 2014 costs for Kansas State Employee Health Plan in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you.

	2013 (this year)	2014 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$161.00	$180.00
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From in-network providers: $1,000 From in-network and out-of-network providers combined: $10,000	From in-network providers: $1,000 From in-network and out-of-network providers combined: $10,000
Doctor office visits	Primary care visits: $10 copay per visit Specialist visits: $25 copay per visit	Primary care visits: $10 copay per visit Specialist visits: $25 copay per visit
Inpatient hospital stays	Days 1-5: $150 copay per day	Days 1-5: $150 copay per day
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0	Deductible: $0
Network Pharmacy (30-day supply)	Copays during the Initial Coverage Stage: • Drug Tier 1: $5 per prescription • Drug Tier 2: $30	Copays during the Initial Coverage Stage: • Drug Tier 1: $5 per prescription • Drug Tier 2: $5 per

	2013 (this year)	2014 (next year)
	per prescription • Drug Tier 3: $60 per prescription • Drug Tier 4: 33% of the total cost • Drug Tier 5: Not applicable in 2013	prescription • Drug Tier 3: $30 per prescription • Drug Tier 4: $60 per prescription • Drug Tier 5: 33% of the total cost

Annual Notice of Changes for 2014

Table of Contents

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

	2013 (this year)	2014 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$161.00	$180.00

- Your monthly plan premium will be *more* if you are required to pay a late enrollment penalty.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amounts

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. These limits are called the "maximum out-of-pocket amounts." Once you reach the maximum out-of-pocket amounts, you generally pay nothing for covered services for the rest of the year.

	2013 (this year)	2014 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$1,000	$1,000 Once you have paid $1,000 out-of-pocket for covered services from in-network providers, you will pay nothing for your covered services from in-network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$10,000	$10,000 Once you have paid $10,000 out-of-pocket for covered services, you will pay nothing for your covered services from in-network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of doctors and other providers for next year.

An updated Provider/Pharmacy Directory is located on our Web site at http://providerdirectory.coventry-medicare.com. You may also call Customer Service for updated provider information or to ask us to mail you a Provider/Pharmacy Directory. **Please review the 2014 Provider/Pharmacy Directory to see if your providers are in our network.**

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. Our network includes preferred pharmacies which may offer you lower cost sharing than other pharmacies within the network.

There are changes to our network of pharmacies for next year.

An updated Provider/Pharmacy Directory is located on our Web site at http://providerdirectory.coventry-medicare.com You may also call Customer Service for updated provider information or to ask us to mail you a Provider/Pharmacy Directory. Please review the 2014 Provider/Pharmacy Directory to see which pharmacies are in our network.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, Medical Benefits Chart (what is covered and what you pay), in your 2014 Evidence of Coverage.

	2013 (this year)	2014 (next year)
Cervical and vaginal cancer screening	You pay a $0 copay for an additional Pap Smear and Pelvic Exam.	An additional Pap Smear and Pelvic Exam is not covered.
Chiropractic Services	You pay a $30 copay for	You pay a $20 copay for

	each Medicare-covered chiropractic visit	each Medicare-covered chiropractic visit
Diabetes Programs and Supplies	You pay a: $0 copay for Medicare-covered Diabetes self-management training. $0 copay for Medicare-covered Diabetes monitoring supplies. $0 copay for Medicare-covered Therapeutic shoes or inserts.	You pay a: $0 copay for glucose monitors and Diabetic test strips from preferred vendor (One Touch/Lifescan). $5 copay for diabetic test strips from non-preferred vendors (non-One Touch/Lifescan), and other diabetic supplies. 20% of the total cost for glucose monitors from non-preferred vendors (non-OneTouch/Lifescan). 20% of the total cost for Medicare-covered Therapeutic shoes or inserts
Emergency Care	If you are admitted to the hospital within 72-hours for the same condition, you pay $0 for the emergency room visit.	If you are admitted to the hospital within 24-hours for the same condition, you pay $0 for the emergency room visit.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or “Drug List.” A copy of our Drug List is in this envelope.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. Review the Drug

List to make sure your drugs will be covered next year and to see if there will be any restrictions.

If you are affected by a change in drug coverage you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **Current members** can ask for an exception before next year and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, you'll be able to get your drug at the start of the new plan year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your Evidence of Coverage *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Customer Service.
- **Find a different drug** that we cover. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition.

In some situations, we will cover a one-time, temporary supply. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the Evidence of Coverage.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Exception requests that were approved in 2013 do not carry over into 2014. If you were granted a formulary exception in 2013, you must request a new formulary exception for 2014. If you do not request a new formulary exception prior to January 1, 2014, the following transition process will apply:

- For currently enrolled members who do not request an exception before January 1, 2014, we will cover up to a 30-day temporary supply (unless your prescription is written for fewer days, in which case we will allow multiple fills to provide up to a total of a 30-day supply) of the drug for the first 90 days of the new plan year starting on January 1st. This will give you time to discuss options with your prescribing physician regarding alternative drugs or requesting an exception if your current drug is not on the formulary next year or has new restrictions.
- For currently enrolled members who are residents in a long-term care facility and do not request an exception before January 1, 2014, we will cover up to a 31-day temporary supply (unless your prescription is written for fewer days, in which case we will allow multiple fills to provide up to a total of a 31-day supply) of the drug for the first 90 days of the new plan year starting on January 1st.This will give you time to discuss options with your prescribing physician regarding alternative drugs or requesting an exception.

- Currently enrolled members who are changing from one treatment setting to another such as:
    - Members who are discharged from a hospital or skilled nursing facility to a home setting.
    - Members who are admitted to a hospital or skilled nursing facility from a home setting.
    - Members who transfer from one skilled nursing facility to another and are served by a different pharmacy.
    - Members who end their skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who need to now use their Part D plan benefit.
    - Members who give up hospice status and revert back to standard Medicare Part A and B coverage.
    - Members discharged from chronic psychiatric hospitals with highly individualized drug regimens.

If you experience a change in treatment setting as described above and a drug therapy is not on the formulary or covered with restrictions, we will cover a 31-day temporary supply if you have not already received a temporary supply in a long term care setting and a 30-day temporary supply for a retail setting.

Regardless of why you received a temporary supply, you will need to utilize our exception process, as defined in the Evidence of Coverage that was in the mailing with this Annual Notice of Changes, if you need to continue on the current drug.

Important Note: Please take advantage of filing your exception requests before January 1st. It will make for a very easy transition into the next calendar year for you. To learn what you must do to ask for an exception, see the Evidence of Coverage that was included in the mailing with this Annual Notice of Changes. Look for Chapter 9 of the Evidence of Coverage (What to do if you have a problem or complaint).

Changes to Prescription Drug Costs

Note*:* If you are in a program that helps pay for your drugs (“Extra Help”), **the information about costs for Part D prescription drugs may not apply to you**. We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also called the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you get "Extra Help" and haven't received this insert by September 30, 2014, please call Customer Service and ask for the “LIS Rider.” Phone numbers for Customer Service are in Section 7.1 of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages - the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages - the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the enclosed *Evidence of Coverage.*)

In addition to the changes in costs described below, there is a change to daily cost sharing that might affect your costs in the Initial Coverage Stage. Starting in 2014, when your doctor first prescribes less than a full month's supply of certain drugs, you may no longer need to pay the copay for a full month. (For more information about daily cost sharing, look at Chapter 6, Section 5.3, in the attached *Evidence of Coverage*.)

Changes to the Deductible Stage

	2013 (this year)	**2014 (next year)**
Stage 1: "Yearly Deductible Stage"	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Copayments in the Initial Coverage Stage	2013 (this year)	2014 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs **and you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier; look them up on the Drug List.	Your cost for a one-month supply: **Preferred Generic Drugs**: Network pharmacies: You pay $5 per prescription **Non-Preferred Generic Drugs**: Network pharmacies: Not offered in 2013 **Preferred Brand Drugs**: Network pharmacies: You pay $30 per prescription **Non-Preferred Brand Drugs**: Network pharmacies: You pay $60 per prescription **Specialty Tier Drugs:** Network pharmacies: You pay 33% of the total cost Once your total drugs costs have reached $2,970 you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply: **Preferred Generic Drugs**: Network pharmacies: You pay $5 per prescription **Non-Preferred Generic Drugs:** Network pharmacies: You pay $5 per prescription **Preferred Brand Drugs**: Network pharmacies: You pay $30 per prescription **Non-Preferred Brand Drugs:** Network pharmacies: You pay $60 per prescription **Specialty Tier Drugs**: Network pharmacies: You pay 33% of the total cost Once your total drugs costs have reached $2,850 you will move to the next stage (the Coverage Gap Stage).

There is another important change that might affect your costs in the Initial Coverage Stage. Generally, your copay has been the same whether you filled your prescription for a full month's supply or for fewer days. However, starting in 2014, your copay for some drugs will be based on the actual number of days' supply you receive rather than a set amount for a month. There may be times when you want to ask your doctor about prescribing less than a full month's supply of a drug (for example, when your doctor first prescribes a drug that is known to cause side effects). If your doctor prescribes less

than a full month's supply of certain drugs, and you are required to pay a copay, you will no longer have to pay for a month's supply. Instead, you will pay a lower copay (a daily cost-sharing rate) based on the number of days of the drug that you receive.

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages - the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Other Changes

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2014.

	2013 (this year)	2014 (next year)
Payment Requests for Part D Prescription Drugs Address Change The address to submit payment requests for Part D Prescription Drugs has changed. For more information refer to Chapter 2, Section 1 of the EOC.	Express Scripts P.O. Box4724 Lexington, KY 40512	Express Scripts Attn: Medicare Part D P.O. Box 2858 Clinton, IA 52733-2858

Changes in Prior Authorization/Referral Requirements	Authorization or referral may apply to select services.	Authorization or referral may apply or have been deleted to select services. You should review Chapter 4, Medical Benefits Chart in the Evidence of Coverage to determine if Authorization or referral still applies to your service. You may also call Customer Service at 1 (800)727-9712.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Kansas State Employee Health Plan

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by November 30, you will automatically stay enrolled as a member of our plan for 2014.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2014 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- -- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan and whether to buy a Medicare supplement (Medigap) policy.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2014*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare Web site. Go to http://www.medicare.gov and click "Compare Drug and Health Plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Kansas State Employee Health Plan.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Kansas State Employee Health Plan.
- To **change to Original Medicare without a prescription drug plan,** you must either:
    - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **November 1 until November 30.** The change will take effect on January 1, 2014.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get “Extra Help” paying for their drugs, and those who move out of the service area are allowed to make a change at other times of the year. For more information, see Chapter 10, of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage plan for January 1, 2014, and don’t like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2014. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state.

- In Arkansas, the SHIP is called Senior Health Insurance Information Program (SHIP) (Arkansas SHIIP)

- In Kansas, the SHIP is called Senior Health Insurance Counseling for Kansas (SHICK).
- In Missouri, the SHIP is called Community Leaders Assisting the Insured in Missouri (CLAIM).
- In Oklahoma, the SHIP is called The Senior Health Insurance Counseling Program (SHIP)

The State Health Insurance Assistance Program is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. State Health Insurance Assistance Program counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans.

Senior Health Insurance Information Program (SHIP) (Arkansas SHIIP)	
CALL	1 (800) 224 6330
WRITE	Arkansas Insurance Department 1200 W Third St Little Rock, AR 72201
WEBSITE	www.insurance.arkansas.gov/Seniors/divpage.htm

Senior Health Insurance Counseling for Kansas (SHICK)	
CALL	1 (800) 860-5260
WRITE	SHICK Kansas Department of Aging 503 S Kansas Ave Topeka, KS 66603
WEBSITE	http://www.kdads.ks.gov/SHICK/shick_index.html

Community Leaders Assisting the Insured in Missouri (CLAIM)	
CALL	1 (800) 390-3330

WRITE	CLAIM 200 N Keene St Columbia, MO 65201
WEBSITE	http://www.missouriclaim.org

The Senior Health Insurance Counseling Program in Oklahoma (SHIP)	
CALL	1 (800) 763 2828
WRITE	Five Corporate Plaza 3625 NW 56th St, Suite 100 Oklahoma City, Ok 73112
WEBSITE	http://ship.oid.ok.gov/

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. There are two basic kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to seventy-five (75) percent or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office.

Help from your state's pharmaceutical assistance program. Missouri has a program called Missouri RX Plan that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 5 of this booklet).

SECTION 7 Questions?

Section 7.1 – Getting Help from Coventry Medicare Advantage (PPO)

Questions? We're here to help. Please call Customer Service at 1 (800) 727-9712. (TTY only, call 711). We are available for phone calls 8 am to 8 pm, seven days a week, from October 1 -. February 14, and 8 am to 8 pm, Monday - Friday, from February 15 - September 30. Calls to these numbers are free.

Read your 2014 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2014. For details, look in the 2014 *Evidence of Coverage* for Coventry Medicare Advantage (PPO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* was included in this envelope.

Visit our Web site

You can also visit our Web site at http://coventry-medicare.coventryhealthcare.com. As a reminder, our Web site has the most up-to-date information about our provider network (Provider/Pharmacy Directory) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Web site

You can visit the Medicare Web site (http://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare Web site. (To view the information about plans, go to http://www.medicare.gov and click on "Compare Drug and Health Plans.")

Read Medicare & You 2014

You can read *Medicare & You 2014* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare Web site (http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

2014

SUMMARY OF BENEFITS

Kansas State Employee Health Plan

Advantra Freedom (PPO)

offered by
Coventry Health and Life Insurance Company

KSEHP (5509)

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

Thank you for your interest in Advantra Freedom (PPO). Our plan is offered by COVENTRY HEALTH AND LIFE INSURANCE COMPANY which is also called COVENTRY HEALTH CARE, a Medicare Advantage Preferred Provider Organization (PPO) that contracts with the Federal government. This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Advantra Freedom (PPO) and ask for the "Evidence of Coverage."

YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (Fee-for-Service) Medicare Plan. Another option is a Medicare health plan, like Advantra Freedom (PPO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may be able to join or leave a plan only at certain times. Please call Advantra Freedom (PPO) at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare Advantra Freedom (PPO) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

WHERE IS Advantra Freedom (PPO) AVAILABLE?

The Service area for this plan includes all continental states, all counties.

WHO IS ELIGIBLE TO JOIN Advantra Freedom (PPO)?

You can join Advantra Freedom (PPO) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End-Stage Renal Disease generally are not eligible to enroll in Advantra Freedom (PPO) unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

Advantra Freedom (PPO) has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time.

You can ask for a current provider directory. For an updated list, visit us at

http://providerdirectory.coventry-medicare.com. Our customer service number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

You can go to doctors, specialists, or hospitals in or out of network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out of network. For more information, please call the customer service number at the end of this introduction.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

Advantra Freedom (PPO) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at http://providerdirectory.coventry-medicare.com. Our customer service number is listed at the end of this introduction.

Advantra Freedom (PPO) has a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower co-pay or co-insurance. You may go to a non-preferred pharmacy, but you may have to pay more for your prescription drugs.

WHAT IF MY DOCTOR PRESCRIBES LESS THAN A MONTH'S SUPPLY?

In consultation with your doctor or pharmacist, you may receive less than a month's supply of certain drugs. Also, if you live in a long-term care facility, you will receive less than a month's supply of certain brand and generic drugs. Dispensing fewer drugs at a time can help reduce cost and waste in the Medicare Part D program, when this is medically appropriate.

The amount you pay in these circumstances will depend on whether you are responsible for paying coinsurance (a percentage of the cost of the drug) or a copay (a flat dollar amount for the drug). If you are responsible for coinsurance for the drug, you will continue to pay the applicable percentage of the drug cost. If you are responsible for a copay for the drug, a "daily cost-sharing rate" will be applied. If your doctor decides to continue the drug after a trial period, you should not pay more for a month's supply than you otherwise would have paid. Contact your plan if you have questions about cost-sharing when less than a one-month supply is dispensed.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

Advantra Freedom (PPO) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Advantra Freedom (PPO) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we

make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected members before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at http://www.FHDFormulary.coventry-medicare.com.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

* 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week; and see http://www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare & You.
* The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
* Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Advantra Freedom (PPO), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision.

Finally, you have the right to file a grievance with us if you have any type of problem

with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of Advantra Freedom (PPO), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision.

Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Advantra Freedom (PPO) for more details.

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Advantra Freedom (PPO) for more details.

-- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.

-- Osteoporosis Drugs: Injectable osteoporosis drugs for some women.

-- Erythropoietin: By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.

-- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.

-- Injectable Drugs: Most injectable drugs administered incident to a physician’s service.

-- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if

the transplant took place in a Medicare-certified facility and was paid for by Medicare or by a private insurance company that was the primary payer for Medicare Part A coverage.

-- Some Oral Cancer Drugs: If the same drug is available in injectable form.

-- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.

-- Inhalation and Infusion Drugs administered through Durable Medical Equipment.

WHERE CAN I FIND INFORMATION ON PLAN RATINGS?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you can find the Plan Ratings information by using the Find health & drug plans web tool on medicare.gov to compare the plan ratings in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

Please call COVENTRY HEALTH CARE for more information about Advantra Freedom (PPO).

Visit us at http://coventry-medicare.coventryhealthcare.com or, call us:

Customer Service Hours for October 1 – February 14:
Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m. Central

Customer Service Hours for February 15 – September 30:
Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m. Central

Current members should call toll-free (800)727-9712 for questions related to the Medicare Advantage Program. (TTY/TDD 711)

Current members should call locally (800)727-9712 for questions related to the Medicare Advantage Program. (TTY/TDD 711)

Current members should call toll-free (866)294-9803 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD 711)

Current members should call locally (866)294-9803 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD 711)

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227).
TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.
Or, visit http://www.medicare.gov on the web.

This document may be available in other formats such as Braille, large print or other alternate formats.

This document may be available in a non-English language. For additional information,

call customer service at the phone number listed above.

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.		
SECTION II - SUMMARY OF BENEFITS		
Benefit	**Original Medicare**	**Advantra Freedom (PPO)**
IMPORTANT INFORMATION		
1 - Premium and Other Important Information	In 2013 the monthly Part B Premium was $104.90 and may change for 2014 and the annual Part B deductible amount was $147 and may change for 2014.	General $180 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.
	If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.	Some physicians, providers and suppliers that are out of a plan's network (i.e., out-of-network) accept "assignment" from Medicare and will only charge up to a Medicare-approved amount. If you choose to see an out-of-network physician who does NOT accept Medicare "assignment," your coinsurance can be based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for out-of-network physician services, the higher Medicare "limiting charge" does not apply. See the publications

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.

SECTION II - SUMMARY OF BENEFITS

Benefit	Original Medicare	Advantra Freedom (PPO)
		Medicare & You or Your Medicare Benefits available on http://www.medicare.gov for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type. To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit http://www.medicare.gov/physician or http://www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment.
	Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	In-Network $1,000 out-of-pocket limit. All plan services included. In and Out-of-Network $10,000 out-of-pocket limit. All plan services included.

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.		
SECTION II - SUMMARY OF BENEFITS		
Benefit	**Original Medicare**	**Advantra Freedom (PPO)**
2 - Doctor and Hospital Choice (For more information, see Emergency Care - #15 and Urgently Needed Care - #16.)	You may go to any doctor, specialist or hospital that accepts Medicare.	In-Network No referral required for network doctors, specialists, and hospitals. In and Out-of-Network You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits.
INPATIENT CARE		
3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	In 2013 the amounts for each benefit period were: Days 1 - 60: $1,184 deductible Days 61 - 90: $296 per day Days 91 - 150: $592 per lifetime reserve day These amounts may change for 2014. Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period	General Prior Authorization applies *(See Chapter 4 in your Evidence of Coverage).* In-Network No limit to the number of days covered by the plan each hospital stay. For Medicare-covered hospital stays: - Days 1 - 5: $150 copay per day - Days 6 - 90: $0 copay per day $0 copay for additional non-Medicare-covered hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Out-of-Network 20% of the cost for each Medicare-covered hospital stay.

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.		
SECTION II - SUMMARY OF BENEFITS		
Benefit	**Original Medicare**	**Advantra Freedom (PPO)**
	has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	
4 - Inpatient Mental Health Care	In 2013 the amounts for each benefit period were: Days 1 - 60: $1,184 deductible Days 61 - 90: $296 per day Days 91 - 150: $592 per lifetime reserve day These amounts may change for 2014. You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.	General Prior Authorization applies *(See Chapter 4 in your Evidence of Coverage).* In-Network You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. For Medicare-covered hospital stays: - Days 1 - 5: $150 copay per day - Days 6 - 90: $0 copay per day Plan covers 60 lifetime reserve days. $0 copay per lifetime reserve day. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Out-of-Network 20% of the cost for each Medicare-covered hospital stay.
5 - Skilled Nursing	In 2013 the amounts for	General

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.		
SECTION II - SUMMARY OF BENEFITS		
Benefit	**Original Medicare**	**Advantra Freedom (PPO)**
Facility (SNF) (in a Medicare-certified skilled nursing facility)	each benefit period after at least a 3-day Medicare-covered hospital stay were: Days 1 - 20: $0 per day Days 21 - 100: $148 per day These amounts may change for 2014. 100 days for each benefit period. A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	Prior Authorization applies *(See Chapter 4 in your Evidence of Coverage).* In-Network Plan covers up to 100 days each benefit period No prior hospital stay is required. For Medicare-covered SNF stays: - Days 1 - 7: $0 copay per day - Days 8 - 100: $50 copay per day Out-of-Network 20% of the cost for each Medicare-covered SNF stay.
6 - Home Health Care (Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	$0 copay.	General Prior Authorization applies *(See Chapter 4 in your Evidence of Coverage).* In-Network $0 copay for Medicare-covered home health visits Out-of-Network

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.		
SECTION II - SUMMARY OF BENEFITS		
Benefit	**Original Medicare**	**Advantra Freedom (PPO)**
		$0 copay for Medicare-covered home health visits
7 - Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice.
OUTPATIENT CARE		
8 - Doctor Office Visits	20% coinsurance	In-Network $10 copay for each Medicare-covered primary care doctor visit. $25 copay for each Medicare-covered specialist visit. Out-of-Network 20% of the cost for each Medicare-covered primary care doctor visit 20% of the cost for each Medicare-covered specialist visit
9 - Chiropractic Services	Supplemental routine care not covered 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part).	In-Network $20 copay for each Medicare-covered chiropractic visit Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part). Out-of-Network 20% of the cost for Medicare-covered chiropractic visits.
10 - Podiatry Services	Supplemental routine care not covered.	In-Network $30 copay for each Medicare-covered podiatry visit

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.		
SECTION II - SUMMARY OF BENEFITS		
Benefit	**Original Medicare**	**Advantra Freedom (PPO)**
	20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	$15 copay for up to 2 supplemental routine podiatry visit(s) every year. Medicare-covered podiatry visits are for medically necessary foot care. Out-of-Network 20% of the cost for Medicare-covered podiatry visits
11 - Outpatient Mental Health Care	20% coinsurance for most outpatient mental health services Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible. "Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	General Prior Authorization is required from contracted Mental Health vendor. Contact information is listed on the back of your health plan ID card. In-Network $30 copay for each Medicare-covered individual therapy visit $15 copay for each Medicare-covered group therapy visit $30 copay for each Medicare-covered individual therapy visit with a psychiatrist $15 copay for each Medicare-covered group therapy visit with a psychiatrist $0 copay for Medicare-covered partial hospitalization program services Out-of-Network 20% of the cost for Medicare-covered Mental Health visits with a psychiatrist 20% of the cost for Medicare-covered Mental Health visits

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.		
SECTION II - SUMMARY OF BENEFITS		
Benefit	**Original Medicare**	**Advantra Freedom (PPO)**
		20% of the cost for Medicare-covered partial hospitalization program services
12 - Outpatient Substance Abuse Care	20% coinsurance	General Prior Authorization is required from contracted Mental Health vendor. Contact information is listed on the back of your health plan ID card. In-Network $30 copay for Medicare-covered individual substance abuse outpatient treatment visits $15 copay for Medicare-covered group substance abuse outpatient treatment visits Out-of-Network 20% of the cost for Medicare-covered substance abuse outpatient treatment visits
13 - Outpatient Services	20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility services Copay cannot exceed the Part A inpatient hospital deductible. 20% coinsurance for ambulatory surgical center facility services	General Prior Authorization applies *(See Chapter 4 in your Evidence of Coverage).* In-Network $150 copay for each Medicare-covered ambulatory surgical center visit $150 copay for each Medicare-covered outpatient hospital facility visit Out-of-Network 20% of the cost for Medicare-covered outpatient hospital facility visits 20% of the cost for Medicare-covered ambulatory surgical center visits

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.		
SECTION II - SUMMARY OF BENEFITS		
Benefit	**Original Medicare**	**Advantra Freedom (PPO)**
14 - Ambulance Services (medically necessary ambulance services)	20% coinsurance	General Prior Authorization applies *(See Chapter 4 in your Evidence of Coverage).* In-Network $100 copay for Medicare-covered ambulance benefits. Out-of-Network $100 copay for Medicare-covered ambulance benefits.
15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility emergency services. Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit. Not covered outside the U.S. except under limited circumstances.	General $50 copay for Medicare-covered emergency room visits Worldwide coverage. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit.

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.		
SECTION II - SUMMARY OF BENEFITS		
Benefit	**Original Medicare**	**Advantra Freedom (PPO)**
16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance, or a set copay If you are admitted to the hospital within 3 days for the same condition, you pay $0 for the urgently-needed-care visit. NOT covered outside the U.S. except under limited circumstances.	General $30 copay for Medicare-covered urgently-needed-care visits
17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered.	General Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered. In-Network $0 copay for Medicare-covered Occupational Therapy visits $0 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits Out-of-Network 20% of the cost for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits 20% of the cost for Medicare-covered Occupational Therapy visits.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.		
SECTION II - SUMMARY OF BENEFITS		
Benefit	**Original Medicare**	**Advantra Freedom (PPO)**
18 - Durable Medical Equipment (Includes wheelchairs, oxygen, etc.)	20% coinsurance	General Prior Authorization is required for DME equipment purchases over $500 and all rental items (except Oxygen). In-Network 20% of the cost for Medicare-covered durable medical equipment Out-of-Network 20% of the cost for Medicare-covered durable medical equipment
19 - Prosthetic Devices (Includes braces, artificial limbs and eyes, etc.)	20% coinsurance 20% coinsurance for Medicare-covered medical supplies related to prosthetics, splints, and other devices.	General Prior Authorization for services and equipment greater than $500 is required. In-Network 20% of the cost for Medicare-covered prosthetic devices 20% of the cost for Medicare-covered medical supplies related to prosthetics, splints, and other devices Out-of-Network 20% of the cost for Medicare-covered prosthetic devices.
20 - Diabetes Programs and Supplies	20% coinsurance for diabetes self-management training 20% coinsurance for diabetes supplies 20% coinsurance for diabetic therapeutic shoes or inserts	General Authorization rules may apply. In-Network $0 copay for preferred glucose meters and test strips. $5 copay for non-preferred vendor test strips, and all other diabetic supplies. 20% coinsurance for non-preferred

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.		
SECTION II - SUMMARY OF BENEFITS		
Benefit	**Original Medicare**	**Advantra Freedom (PPO)**
		vendor glucose monitors and Therapeutic shoes and inserts. Diabetic Supplies and Services are limited to specific manufacturers, products and/or brands. Contact the plan for a list of covered supplies. If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing may apply Out-of-Network 20% of the cost for Medicare-covered Diabetes self-management training 20% of the cost for Medicare-covered Diabetes monitoring supplies 20% of the cost for Medicare-covered Therapeutic shoes or inserts
21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	20% coinsurance for diagnostic tests and x-rays $0 copay for Medicare-covered lab services Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare.	General Prior Authorization applies *(See Chapter 4 in your Evidence of Coverage).* In-Network $0 copay for Medicare-covered lab services $0 copay for Medicare-covered diagnostic procedures and tests $0 copay for Medicare-covered X-rays $0 copay for Medicare-covered diagnostic radiology services (not including X-rays)

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.		
SECTION II - SUMMARY OF BENEFITS		
Benefit	**Original Medicare**	**Advantra Freedom (PPO)**
	Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol.	$0 copay for Medicare-covered therapeutic radiology services If a doctor provides services in addition to diagnostic tests and therapeutic services, separate physician or facility cost share may apply. If you obtain Outpatient Diagnostic MRI/PET services at a Hospital or Ambulatory Surgical facility a separate facility copay may apply. Out-of-Network 20% of the cost for Medicare-covered therapeutic radiology services 20% of the cost for Medicare-covered outpatient X-rays 20% of the cost for Medicare-covered diagnostic radiology services 20% of the cost for Medicare-covered diagnostic procedures and tests 20% of the cost for Medicare-covered lab services

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.		
SECTION II - SUMMARY OF BENEFITS		
Benefit	**Original Medicare**	**Advantra Freedom (PPO)**
22 - Cardiac and Pulmonary Rehabilitation Services	20% coinsurance for Cardiac Rehabilitation services 20% coinsurance for Pulmonary Rehabilitation services 20% coinsurance for Intensive Cardiac Rehabilitation services	General Authorization rules may apply. In-Network $0 copay for Medicare-covered Cardiac Rehabilitation Services $0 copay for Medicare-covered Intensive Cardiac Rehabilitation Services $0 copay for Medicare-covered Pulmonary Rehabilitation Services Out-of-Network 20% of the cost for Medicare-covered Cardiac Rehabilitation Services 20% of the cost for Medicare-covered Intensive Cardiac Rehabilitation Services 20% of the cost for Medicare-covered Pulmonary Rehabilitation Services
PREVENTIVE SERVICES		
23 -Preventive Services	No coinsurance, copayment or deductible for the following: - Abdominal Aortic Aneurysm Screening - Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. - Cardiovascular Screening - Cervical and Vaginal	General $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. Out-of-Network 20% of the cost for Medicare-covered preventive services

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.

SECTION II - SUMMARY OF BENEFITS

Benefit	Original Medicare	Advantra Freedom (PPO)
	Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. - Colorectal Cancer Screening - Diabetes Screening - Influenza Vaccine - Hepatitis B Vaccine for people with Medicare who are at risk - HIV Screening. $0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. - Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women	

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.		
SECTION II - SUMMARY OF BENEFITS		
Benefit	**Original Medicare**	**Advantra Freedom (PPO)**
	between ages 35-39. - Medical Nutrition Therapy Services Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease - Personalized Prevention Plan Services (Annual Wellness Visits) - Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. - Prostate Cancer Screening - Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. - Smoking and Tobacco Use Cessation (counseling to stop smoking and tobacco use). Covered if ordered by your doctor. Includes	

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.

SECTION II - SUMMARY OF BENEFITS

Benefit	Original Medicare	Advantra Freedom (PPO)
	two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. - Screening and behavioral counseling interventions in primary care to reduce alcohol misuse - Screening for depression in adults - Screening for sexually transmitted infections (STI) and high-intensity behavioral counseling to prevent STIs - Intensive behavioral counseling for Cardiovascular Disease (bi-annual) - Intensive behavioral therapy for obesity - Welcome to Medicare Preventive Visits (initial preventive physical exam) When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Preventive Visits or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months.	

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.		
SECTION II - SUMMARY OF BENEFITS		
Benefit	**Original Medicare**	**Advantra Freedom (PPO)**
24 - Kidney Disease and Conditions	20% coinsurance for renal dialysis 20% coinsurance for kidney disease education services	General Prior Authorization applies *(See Chapter 4 in your Evidence of Coverage).* In-Network $0 copay for Medicare-covered renal dialysis $0 copay for Medicare-covered kidney disease education services Out-of-Network 20% of the cost for Medicare-covered kidney disease education services 20% of the cost for Medicare-covered renal dialysis
PRESCRIPTION DRUG BENEFITS		
25 - Outpatient Prescription Drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can	Drugs covered under Medicare Part B General 20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. 20% of the cost for Medicare Part B drugs out-of-network.

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.

SECTION II - SUMMARY OF BENEFITS

Benefit	Original Medicare	Advantra Freedom (PPO)
	get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	Drugs covered under Medicare Part D General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.FHDFormulary.coventry-medicare.com on the web. Different out-of-pocket costs may apply for people who -have limited incomes, -live in long term care facilities, or -have access to Indian/Tribal/Urban (Indian Health Service) providers. The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from Advantra Freedom (PPO) for certain drugs. The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and work just as well.

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.

SECTION II - SUMMARY OF BENEFITS

Benefit	Original Medicare	Advantra Freedom (PPO)
		Contact the plan for details. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Advantra Freedom (PPO) approves the exception, you will pay Tier 4: Non-Preferred Brand cost sharing for that drug. **In-Network** $0 deductible. **Initial Coverage** You pay the following until total yearly drug costs reach $2,850: **Retail Pharmacy** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. You can get drugs from a preferred and non-preferred pharmacy the following way(s): **Tier 1: Preferred Generic** - $5 copay for a one-month (30-day) supply of drugs in this tier from a

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.

SECTION II - SUMMARY OF BENEFITS

Benefit	Original Medicare	Advantra Freedom (PPO)
		preferred pharmacy - $10 copay for a two-month (60-day) supply of drugs in this tier from a preferred pharmacy - $10 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 2: Non-Preferred Generic** - $5 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy - $10 copay for a two-month (60-day) supply of drugs in this tier from a preferred pharmacy - $10 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 3: Preferred Brand** - $30 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy - $60 copay for a two-month (60-day) supply of drugs in this tier from a preferred pharmacy - $60 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.

SECTION II - SUMMARY OF BENEFITS

Benefit	Original Medicare	Advantra Freedom (PPO)
		Tier 4: Non-Preferred Brand - $60 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy - $120 copay for a two-month (60-day) supply of drugs in this tier from a preferred pharmacy - $120 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 5: Specialty Tier** - 33% coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy **Long Term Care Pharmacy** Long term care pharmacies must dispense brand name drugs in amounts less than a 14 days supply at a time. They may also dispense less than a month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. You can get drugs the following way(s): **Tier 1: Preferred Generic** - $5 copay for a one-month (31-day) supply of drugs in this tier **Tier 2: Non-Preferred Generic** - $5 copay for a one-month (31-day) supply of drugs in this tier **Tier 3: Preferred Brand**

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.		
SECTION II - SUMMARY OF BENEFITS		
Benefit	**Original Medicare**	**Advantra Freedom (PPO)**
		- $30 copay for a one-month (31-day) supply of drugs in this tier **Tier 4: Non-Preferred Brand** - $60 copay for a one-month (31-day) supply of drugs in this tier **Tier 5: Specialty Tier** - 33% coinsurance for a one-month (31-day) supply of drugs in this tier **Mail Order** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. You can get drugs the following way(s): **Tier 1: Preferred Generic** - $5 copay for a one-month (30-day) supply of drugs in this tier - $10 copay for a two-month (60-day) supply of drugs in this tier - $10 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 2: Non-Preferred Generic** - $5 copay for a one-month (30-day) supply of drugs in this tier - $10 copay for a two-month (60-day) supply of drugs in this tier - $10 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.

SECTION II - SUMMARY OF BENEFITS

Benefit	Original Medicare	Advantra Freedom (PPO)
		Tier 3: Preferred Brand - $30 copay for a one-month (30-day) supply of drugs in this tier - $60 copay for a two-month (60-day) supply of drugs in this tier - $60 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 4: Non-Preferred Brand** - $60 copay for a one-month (30-day) supply of drugs in this tier - $120 copay for a two-month (60-day) supply of drugs in this tier - $120 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Coverage Gap** The Plan covers some prescription drugs through the coverage gap. Please reference the separate Certificate of Insurance for Retiree Prescription Drug Program at the end of this *Summary of Benefits* booklet. **Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: - 5% coinsurance, or - $2.55 copay for generic (including brand drugs treated as generic) and a $6.35 copay for all other drugs. **Out-of-Network** Plan drugs may be covered in special

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.		
SECTION II - SUMMARY OF BENEFITS		
Benefit	**Original Medicare**	**Advantra Freedom (PPO)**
		circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Advantra Freedom (PPO). You can get out-of-network drugs the following way: **Out-of-Network Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,850: **Tier 1: Preferred Generic** - $5 copay for a one-month (30-day) supply of drugs in this tier **Tier 2: Non-Preferred Generic** - $5 copay for a one-month (30-day) supply of drugs in this tier **Tier 3: Preferred Brand** - $30 copay for a one-month (30-day) supply of drugs in this tier **Tier 4: Non-Preferred Brand** - $60 copay for a one-month (30-day) supply of drugs in this tier **Tier 5: Specialty Tier** - 33% coinsurance for a one-month (30-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.		
SECTION II - SUMMARY OF BENEFITS		
Benefit	**Original Medicare**	**Advantra Freedom (PPO)**
		Network allowable amount. **Out-of-Network Coverage Gap** The Plan covers some prescription drugs through the coverage gap. Please reference the separate Certificate of Insurance for Retiree Prescription Drug Program at the end of this *Summary of Benefits* booklet. **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: - 5% coinsurance, or - $2.55 copay for generic (including brand drugs treated as generic) and a $6.35 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
26 - Dental Services	Preventive dental services (such as cleaning) not covered.	In-Network This plan only covered Medicare-covered dental services. $0 copay for Medicare-covered dental office services. $150 copay for Medicare-covered dental services in an outpatient facility. Out-of-Network 20% of the cost for Medicare-covered comprehensive dental benefits

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.		
SECTION II - SUMMARY OF BENEFITS		
Benefit	**Original Medicare**	**Advantra Freedom (PPO)**
27 - Hearing Services	Supplemental routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	In-Network $0 copay for Medicare-covered diagnostic hearing exams $0 copay for up to one routine hearing test every year You are covered up to $500 for hearing aids every three years Out-of-Network 20% of the cost for Medicare-covered diagnostic hearing exams.
28 - Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye, including an annual glaucoma screening for people at risk Supplemental routine eye exams and eyeglasses (lenses and frames) not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.	In-Network Non-Medicare covered eyeglasses not covered. $0 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye $0 copay for up to 1 supplemental routine eye exam(s) every year $0 copay for - one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery If the doctor provides you services in addition to eye exams, separate cost sharing of $25 may apply Out-of-Network 20% of the cost for Medicare-covered eye exams 20% of the cost for supplemental routine eye exams

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.		
SECTION II - SUMMARY OF BENEFITS		
Benefit	**Original Medicare**	**Advantra Freedom (PPO)**
		20% of the cost for Medicare-covered eyewear
Wellness/ Education and Other Supplemental Benefits & Services	Not covered.	In-Network The plan covers the following supplemental education/wellness programs: - Nutritional Benefit - Health Club Membership/Fitness Classes - Nursing Hotline Out-of-Network $50 copay for supplemental education/wellness programs
Over-the-Counter	Not covered.	General

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.		
SECTION II - SUMMARY OF BENEFITS		
Benefit	**Original Medicare**	**Advantra Freedom (PPO)**
Items		The plan does not cover Over-the-Counter items.
Transportation (Routine)	Not covered.	In-Network This plan does not cover supplemental routine transportation.
Acupuncture and Other Alternative Therapies	Not covered.	In-Network This plan does not cover Acupuncture and other alternative therapies.

Kansas State Employee Health Plan

CERTIFICATE OF INSURANCE
for
RETIREE PRESCRIPTION DRUG PROGRAM

Offered by
Coventry Health & Life Insurance Company

DESCRIPTION OF COVERAGE: Covered Drugs are provided through Participating Pharmacies. Covered Drugs are subject to quantity limits, formulary limitations, prior authorization requirements and, in some cases, no coverage for non-compliance. Coverage for prescriptions filled at Non-Participating Pharmacies is limited.

PLEASE NOTE: THIS COVERAGE IS BEING PROVIDED IN ADDITION TO YOUR ADVANTRA PRESCRIPTION DRUG COVERAGE AND IS LIMITED TO COVERAGE FOR COVERED DRUGS THAT QUALIFY FOR THE COVERAGE GAP DISCOUNT.

INTRODUCTION

This Certificate of Insurance is issued to Members as part of the Group Contract entered into between the Contract Holder and Coventry Health & Life Insurance Company (referred to in this Certificate of Insurance as the "Plan"). It explains your coverage with the Plan. Capitalized words are defined in Article I –Definitions. All of the terms and conditions, including, but not limited to, defined terms, contained in this Certificate of Insurance are binding on the Plan, the Contract Holder and all Members. This Certificate of Insurance may be amended from time to time.

This Certificate of Insurance replaces any other Certificates of Insurance that may have been issued to Members previously under the Group Contract for this product.

Read this Certificate of Insurance carefully to determine which health care services are covered. The Plan's Customer Services Department is available to respond to your questions.

Brad Clothier
President

TABLE OF CONTENTS

ARTICLE I - DEFINITIONS

Any capitalized term listed in this Article I shall have the meaning set forth below whenever the capitalized term is used in this Certificate of Insurance.

1.1 **Adverse Benefit Determination**: A denial, reduction, or termination of, or failure to pay (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to pay for a benefit that is based on a determination of Member's plan eligibility, application of utilization review, and failure to cover a benefit because it is Experimental/Investigational or not Medically Necessary or appropriate and a rescission of coverage as well as any other cancellation or discontinuance of coverage that has a retroactive effect, except when such cancellation/discontinuance is due to a failure to timely pay required premiums or contributions towards the cost of coverage.

1.2 **Anniversary Date:** Shall mean the original Group Effective Date and the subsequent annual anniversaries of that date.

1.3 **Authorized Representative:** Shall mean an individual authorized by the Member to act on the Member's behalf to submit appeals and file claims. A provider may act on behalf of a Member with the Member's express consent, or without the Member's express consent in an emergency situation.

1.4 **Benefit Year:** The period of twelve (12) consecutive months during which coverage for Covered Drugs under this Certificate of Insurance accrue.

1.5 **Certificate of Insurance**: Shall mean this document that is issued to Members pursuant to the Group Policy.

1.6 **Contract Holder:** Shall mean the organization or firm , usually your employer, union or association, that contracts with the Plan to provide coverage for Covered Drugs for Subscribers. The Contract Holder is identified in the Group Policy.

1.7 **Contract Year**: Shall mean a period of twelve (12) consecutive months, beginning on each Anniversary Date.

1.8 **Copayment:** The flat dollar amount as specified in Article VII - Benefits that will be charged to You by the Participating Pharmacy to dispense any Prescription Order or Refill. You are required to pay one Copayment per each Prescription Order or Refill at the time of service.

1.9 **Coverage Gap:** The portion of Covered Drugs that are not covered by Your Advantra Medicare prescription drug coverage (Part D) (sometimes referred to as the "donut hole"). The Coverage Gap is subject to the Out-of-Pocket Cost and is not available if Medicare is not the primary payer or You are receiving Extra Help.

1.10 **Coverage Gap Discount**: The discount You are eligible to receive for Covered Drugs subject to the Coverage Gap. The Coverage Gap Discount is subject to the Out-of-Pocket Cost and is not available if Medicare is not the primary payer or You are receiving Extra Help.

1.11 **Covered Drugs:** Prescription Drugs that are:

(i) Covered under Your Advantra Medicare prescription drug coverage (Part D) but currently subject to the Coverage Gap;
(ii) For which you are eligible to receive the Coverage Gap discount;
(iii) and listed in the Drug Formulary or Non-Formulary Drugs that are covered pursuant to the Group Contract in accordance with this Certificate of Insurance;
(iv) prescribed by a Prescriber;
(v) approved by Us; and
(iv) not otherwise excluded.

Covered Drugs do not include any Prescription Drugs that are covered under a Subscriber's Medicare Advantra coverage or are not eligible for the Coverage Gap Discount.

1.12 **Drug Formulary:** List of Prescription Drugs that the Pharmacy and Therapeutics Committee has approved for coverage under this Certificate of Insurance. The Drug Formulary is available for review:

(i) in the Prescriber's office;
(ii) by contacting the Customer Service Department; or
(iii) on the Internet at http://www.FHDFormulary.coventry-medicare.com

1.13 **Eligible Charges**: Shall mean the lesser of :

(i) the rate that We have agreed to pay the Participating Pharmacy for a Covered Drug; or
(ii) The pharmacy's billed charges for the Covered Drug.

1.14 **ERISA:** Shall mean, collectively, the Employee Retirement Income Security Act of 1974 and its related regulations, each as amended.

1.15 **Experimental or Investigational:** A health product or service is deemed Experimental or Investigational if one or more of the following conditions are met:

- Any drug not approved for use by the FDA; any FDA approved drug prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed Medical Literature; or, any drug that is classified as IND (investigational new drug) by the FDA. As used herein, off-label prescribing means prescribing prescription drugs for treatments other than those stated in the labeling approved by the FDA.
- Any health product or service that is subject to Institutional Review Board (IRB) review or approval;
- Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II, III, or IV as set forth by FDA regulations, except as otherwise covered under Your Medicare Advantra policy;
- Any health product or service whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed Medical Literature.

1.16 **Extra Help**: A Medicare program to help people with limited income or resources pay Medicare prescription drug costs.

1.17 **Genetic Services:** a genetic test, genetic counseling (including obtaining, interpreting or assessing genetic information), or genetic education.

1.19 **Genetic Testing**: an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes. "Genetic test" does not include an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes, or an analysis of proteins or metabolites is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

1.20 **Grievance:** A dispute or objection that has not been resolved by the Plan and that is regarding a health care provider, the Plan's operations or management, the Member's benefit coverage or any issue related to an Adverse Benefit Determination.

1.21 **Group Application**: Shall mean the document provided by the Plan that the Contract Holder used to apply for coverage.

1.22 **Group Contract:** Shall mean the Group Policy and this Certificate of Insurance.

1.23 **Group Effective Date**: Shall mean the date that is specified in the Group Policy as the original date that the Group Contract begins.

1.24 **Group Enrollment Period**: Shall mean a period of time designated by the Contract Holder occurring at least once annually during which any eligible Retiree may enroll himself/herself for coverage under the Group Contract.

1.25 **Group Policy**: Shall mean the legal agreement between Contract Holder and the Plan for coverage of Covered Drugs.

1.26 **Legend Medication**: A drug that, by law, can be obtained only by prescription and that is labeled "Caution: federal law prohibits dispensing without a prescription."

1.27 **Long-Term Supply (extended supply)**: A long-term supply of up to 90 days may be available for some types of drugs. Specialty Drugs are not eligible for a long-term supply.

1.28 **Mail Order/90 Day Pharmacy**: The Participating Pharmacy contracted by Us to provide Maintenance Drugs through the mail, when applicable.

1.29 **Maintenance Drugs**: A Prescription Drug that is anticipated to be required for six (6) months or more to treat a chronic condition, such as high blood pressure or diabetes, and designated by Us as a Maintenance Drug

1.30 **Medically Necessary or Medical Necessity**: Shall mean those services, supplies, equipment
and facilities charges that are not expressly excluded under the Group Contract and are:

(i) medically appropriate, so that expected health benefits (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks*;*

(ii) necessary to meet the health needs of the Member as a minimum requirement, improve physiological function and required for a reason other than improving appearance;

(iii) rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service without compromising the quality of care;

(i) consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are generally accepted as national authorities on the services, supplies, equipment or facilities for which coverage is requested;

(ii) consistent with the diagnosis of the condition at issue;

(iii) required for reasons other than the comfort or convenience of the Member or his or her physician; and

(iv) not experimental or investigational as determined by the Plan under its Experimental Procedures Determination Policy or related policies.

The fact that a Participating Health Care Provider may prescribe, recommend, order, or approve a service or supply does not of itself determine Medical Necessity or make such service or supply a covered Benefit.

1.31 **Member**: Shall mean a Subscriber who is enrolled for coverage under the Group Contract in accordance with its terms and conditions.

1.32 **Member Effective Date**: Shall mean the date when a Member's coverage under the Group Contract begins.

1.33 **Narrow Therapeutic Index**: A drug is said to have a narrow therapeutic index when small variances in a Member's blood levels can change the effectiveness or toxicity of the drug. Safe and effective use of these drugs requires careful dosage adjustment and patient monitoring, regardless of whether the generic or brand name product is used.

1.34 **Notice of Benefit Determination**: Shall mean a notice of approval, denial, reduction or termination of benefits, or the failure to provide or pay for benefits.

1.35 **Out-of-Pocket Cost**: The dollar amount determined by CMS and calculated during the Benefit Year after which Prescription Drugs are no longer subject to the Coverage Gap.

The Out-of-Pocket Cost is calculated by adding: (i) Your Copayments under Your Medicare Advantra coverage and this Certificate of Insurance; and (ii) the amount of Your Coverage Gap Discount used during the Benefit Year, up to the maximum amount allowed by Medicare.

1.36 **Participating Pharmacy**: Participating Retail Pharmacy or Mail Order/90 Day Pharmacy, as applicable

1.37 **Participating Retail Pharmacy**: A registered, licensed retail Pharmacy with which the Plan has directly or indirectly contracted to dispense Covered Drugs to Members.

1.38 **Pharmacy and Therapeutic Committee (Committee)**: The Plan's panel of physicians, pharmacists, nurses, and other health care professionals who are responsible for all pharmacy management activities, such as managing, updating and administering the Drug Formulary

1.39 **Plan**: Coventry Health & Life Insurance Company

1.40 **Post-service Appeal**: Shall mean a Grievance or appeal regarding an Adverse Benefit Determination for a Post-service Claim.

1.41 **Post-service Claim**: Shall mean a claim for payment for medical care that the Member has already received.

1.42 **Prescriber**: Any physician, dentist or other provider who is duly licensed to prescribe Prescription Drugs in the ordinary course of his or her professional practice.

1.43 **Prescription Drug**: A drug approved by the FDA for a specific outpatient use and that is dispensed only pursuant to a Prescription Order or Refill (a Legend Medication) under applicable law.

1.44 **Prescription Order or Refill**: The authorization for a Prescription Drug issued by a Prescriber.

1.45 **Pre-service Appeal**: Shall mean a Grievance or appeal regarding an Adverse Benefit Determination for a Pre-service Claim.

1.46 **Pre-service Claim**: Shall mean a request for a benefit that has not yet been received and for which preauthorization is required.

1.47 **Prior Authorization**: A determination by Us or Our designee that a Prescription Order or Refill otherwise covered under this Certificate of Insurance has been reviewed and, based upon the information provided, the Prescription Order or Refill satisfies Our Medical Necessity requirements for Covered Drugs.

1.48 **Retail Copayment**: The amount that will be charged to You by the Participating Retail Pharmacy to dispense or refill any Prescription Order or Refill. You shall be required to pay one (1) Retail Copayment per each Prescription Order or Refill. You are responsible for payment of the Retail Copayment directly to the Participating Retail Pharmacy at the time of service. The Retail Copayment amount is shown in Article VII - Benefits

1.49 **Retiree**: Shall mean a former employee of the Contract Holder or a union or association member who is retired from employment who meets the Contract Holder's definition of retired employees to whom the Contract Holder offers coverage under the Group Contract. Not all retired persons are considered Retirees under the Group Contract. The Contract Holder must designate and the Plan agree that one or more classes of retired former employees of the Contract Holder are eligible to receive coverage under the Group Contract in order for a person to qualify as a Retiree.

1.50 **Specialty Drugs**: (Tier 4 Drugs) – Includes high cost/unique drugs. Specialty Drugs include both Generic and Brand Drugs. A Long-Term Supply (90 days) is not available for Specialty Drugs

1.51 **Subscriber**: Shall mean a Retiree or a Retiree's lawful spouse.

1.52 **Tier 1**: Tier 1 contains all of the Plan's Preferred Generic Drugs for the lowest copayment. See Your Drug Formulary to determine which Tier Your Covered Drug is listed in.

1.53 **Tier 2**: Tier 2 contains all of the Plan's Preferred Brand Drugs for a copayment that is higher than

Tier 1. See Your Drug Formulary to determine which Tier Your Covered Drug is listed in.

1.54 **Tier 3**: Tier 3 contains all of the Plan's Non-Preferred Brand Drugs and some non-preferred generics for a copayment that is higher than Tiers 1 and 2. See Your Drug Formulary to determine which Tier Your Covered Drug is listed in.

1.55 **Tier 4**: Tier 4 contains all of the Plan's Specialty Tier Drugs for a copayment that is higher than
Tiers 1, 2, and 3. See Your Drug Formulary to determine which Tier Your Covered Drug is listed in.

1.56 **Urgent Care Appeal**: Shall mean an Appeal that must be reviewed under the expedited Urgent Care Appeal process because the application of non-Urgent Care Appeal timeframes could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function. An Urgent Care Appeal is also an Appeal involving care that the treating physician deems urgent in nature, or the treating physician determines that a delay in care would subject the Member to severe pain that could not be adequately managed without the care or treatment that is being requested.

1.57 **Utilization Management Policies and Procedures**: a review process which is designed to ensure that Covered health care services are Medically Necessary and are provided in the most cost-effective manner by using documented clinical review criteria and written procedures for making determinations. Utilization Management Policies and Procedures include, but are not limited to, Prior Authorization, Prospective Review, Concurrent Review, and Retrospective Review.

1.58 **We or Us or Our**: Coventry Health & Life Insurance Company

1.59 **Year**: the period during which the total amount of annual benefits under Your Coverage is calculated. The Year is the period of twelve (12) consecutive months that starts on the date defined in the Group Contract and each subsequent anniversary of that date.

1.60 **You or Your**: a Member Covered under this Group Contract.

ARTICLE II – ELIGIBILITY

2.1 Eligibility. To be eligible to be enrolled in this Certificate of Coverage, an individual must:

i. be a Retiree of the Contract Holder enrolled in Medicare Part A and B and eligible to receive the Coverage Gap discount; and

ii. be eligible to participate equally in any alternate retiree health benefits plan offered by the Contract Holder by virtue of his/her own status with the Contract Holder, and not by virtue of dependency; and

iii. be enrolled within the Contract Holder's Group Policy, and

iv. complete and submit to the Plan such applications or forms that the Plan may reasonably request.

2.2 Persons Not Eligible To Enroll

A. A person who fails to meet the eligibility requirements specified in the Group Contract shall not be eligible to enroll or continue enrollment with the Plan for coverage under the Group Contract.

B. Dependents of the subscriber. A separate contract will be established for dependents who also meet all Eligibility requirements under this Group Contract.

2.3 In compliance with the Genetic Information Nondiscrimination Act of 2008, the Plan does not request, require, purchase or consider genetic information for underwriting purpose or in connection with enrollment. "Underwriting purposes" includes establishing rules for eligibility for benefits, determining eligibility or continued eligibility in the Group Contract, calculating premium or contribution amounts, applying pre-existing condition exclusions, and other activities related to the creation, renewal or replacement of a Group Contract or health benefits.

The term "genetic information" includes:

- genetic tests of an individual;
- genetic tests of the individual's family members;
- any request for or receipt of genetic services or participation in clinical research which includes genetic services by an individual or a family member;
- the manifestation of a disease or disorder in family members of the individual;
- the genetic information of the fetus carried by a pregnant woman; or with respect to an individual or family member utilizing assisted reproductive technology, the genetic information of any embryo legally held by the individual or family member

ARTICLE III - EFFECTIVE DATES

3.1 The Group Contract shall become effective upon the Group Effective Date. Members shall be eligible for coverage under this Certificate of Insurance as stated below.

3.2 Member Effective Date: A Retiree who is eligible for coverage under the Group Contract and enrolls for such coverage during a Group Enrollment Period shall be covered under the Group Contract on the Member Effective Date.

ARTICLE IV - TERMINATION, CANCELLATION, RENEWAL AND REINSTATEMENT

4.1 Termination Of Group Contract And Renewal

A. Term: The term of the Group Contract shall be for one (l) year from the Group Effective Date, with annual renewals thereafter upon the first day of each Contract Year, unless terminated as set forth in the Group Contract.

B. Termination by Contract Holder:

i. The Contract Holder may terminate the Group Contract on any Anniversary Date upon sixty (60) days written notice to the Plan. Such terminations will be effective at 11:59 PM on the last day of the then current Contract Year.

ii. The Contract Holder may terminate the Group Contract upon sixty (60) days written notice to The Plan upon material violation of any of the terms and provisions hereof, provided that the Plan shall have thirty (30) days to

correct such violation and the termination shall not occur if the Plan corrects the violation.

C. Termination by the Plan:

i. In the event that any payment due to the Plan is not made within thirty-one (31) days after the date it is due, the Group Contract may terminate and coverage hereunder for all Members shall cease upon the day that the Plan notifies Contract Holder that coverage shall cease; provided that such coverage shall not cease sooner than the thirty-second (32^{nd}) day after the day payment is due and coverage for Members shall continue as set forth in Section 4.1.F. below.

ii. If the Contract Holder performed and act or practice constituting fraud or intentionally misrepresented material facts in connection with coverage under the Group Contract, the Plan may:

1. terminate Coverage for all Members enrolled in the Contract Holder's plan at 11:59 p.m. upon the date set forth in Our notice of termination to the Contract Holder. Such termination may occur back to the original Group Effective Date; or
2. re-evaluate the medical history of the Group's Members and revise the Group's premium rates for Coverage. Such change in premium rate may be enforced back to the original Group Effective Date or its most recent Anniversary Date.

iii. the Plan may terminate the Group Contract on any Anniversary Date or anytime during the Contract Year upon sixty (60) days written notice to Contract Holder if the Contract Holder has failed to comply with a material provision of this Group Contract regarding eligibility.

iv. The Plan may terminate the Group Contract on any Anniversary Date or anytime during the Contract Year upon ninety (90) days written notice to Contract Holder if the Plan ceases to offer the Group Contract in the market in which the Contract Holder is located.

D. IN THE EVENT THAT THE GROUP CONTRACT IS TERMINATED FOR ANY REASON, THE CONTRACT HOLDER SHALL BE RESPONSIBLE FOR NOTIFYING MEMBERS OF TERMINATION OF COVERAGE.

E. Termination Of Coverage For Members:

Coverage shall terminate upon the occurrence of any one of the following events:

i. At least fifteen (15) days written notice to the Member if the Member no longer meets the eligibility requirements set forth in the Group Contract.

ii. Upon the day provided in the notice to Contract Holder of termination due to one of the reasons set forth in Article 4.1.C. above.

iii. Upon the date specified in the notice to the Member if the Member participated in fraudulent or criminal behavior, including but not limited to:

a. Performing an act or practice that constitutes fraud or intentionally misrepresenting material facts. This includes, but is not limited to, using an

identification card to obtain goods or services which are not prescribed or ordered for him/her or to which he/she is otherwise not legally entitled.

b. Allowing any other person to use an identification card to obtain services.

c. Threatening or carrying out violent acts against the Plan, a health care provider, or an employee of the Plan or a health care provider.

d. Knowingly misrepresenting or giving false information on any enrollment application form which is material to the Plan's acceptance of such application.

Except in the case for fraud or intentional misrepresenting material fact as stated in b) v) of this section, the Plan will provide a thirty (30) calendar day advanced notice before coverage is rescinded. Members have the right to request an internal appeal of the rescission of coverage. After the internal appeal process has been exhausted, You have the right to request an independent external review.

F. If a Member's coverage under the Group Contract is terminated under this Article 4.1, all coverage under the Group Contract shall cease at 11:59 PM on the date of the termination.

G. A Member cannot be terminated based on the status of the Member's health or the Member's use of the Plan's complaint procedures. The Plan may not terminate a Group Contract solely for the purpose of disenrolling a Member for either of these reasons.

H. Contract Holders are responsible for any Premiums due before or during any grace period that the Group Contract is in effect. Members are responsible for any Copayments and Financial Penalties for Covered Drugs received during any grace period that the Group Contract is in effect.

ARTICLE V - CLAIMS, INQUIRY AND APPEAL PROCEDURES

5.1 Notice of Benefit Determination

A. Pre-Service Claims

Two (2) business days from the date that the Plan receives all necessary information. In the event that the Plan does not receive all necessary information in fourteen (14) calendar days after the request for services, a decision will be made based on the information received. In the case of a determination to certify an admission, procedure or service, the Plan shall notify the provider rendering the service by telephone within twenty-four (24) hours of making the initial certification, and provide You and the Provider written or electronic confirmation of the telephone notification within two (2) working days of making the initial certification.

B. Post-Service Claims

Thirty (30) calendar days from the date that the Plan receives the request for determination. The Plan shall provide You written notice of determination within ten (10) working days of making the determination.

C. Ongoing Treatment

The Plan does not reduce or terminate care that is preauthorized, as long as the information the Plan was provided to obtain the preauthorization is accurate and the Member remains enrolled in the plan.

E. Reconsideration

You have the right to request reconsideration of any adverse determination involving a prospective or pre-service review as well as any concurrent care review determination.

Such reconsideration shall occur within one (1) working day of the receipt of the request and shall be conducted between the Provider rendering the service and the reviewer who made the adverse determination or a clinical peer designated by the reviewer if the reviewer who made the adverse determination is not available within one (1) working day.

5.2 Complaint

Complaints may be expressed by telephone or in person and are handled by Our Customer Service Department. The Customer Service Department may involve one or more staff members of the Plan or Providers of health care before making a determination. The objective is to review all the facts and to handle the Complaint as quickly and as courteously as possible.

Written Complaints will be acknowledged in writing by the Plan within five (5) working days after receipt of the Complaint. The Plan will conduct an investigation within twenty (20) working days after receipt of the respective Complaint, unless the investigation cannot be completed within this time. If the investigation cannot be completed within the 20-day timeframe, You will be notified in writing by the 20th working day of the specific reasons for the delay, and the investigation will be completed within 30 working days thereafter. You will be notified of the resolution within five (5) working days after the investigation of the respective Complaint is completed. Within fifteen (15) working days after the investigation of the respective Complaint is completed, the person, if other than You, who submitted the Complaint will be notified.

The address and telephone numbers for Complaints are:

Coventry Health & Life Insurance Company Medicare Products
Part D Appeals and Grievances Department
P.O. Box 7773
London, KY 40742
Telephone: 1 (877) 417-8650

5.3 Appeal Process

A Member or Authorized Representative has one hundred eighty (180) days from the date of receipt of an Adverse Benefit Determination to file an Appeal with the Plan. Requests received after one hundred eighty (180) days will not be eligible for the internal Appeal process. The Appeals may be submitted in writing to:

Coventry Health & Life Insurance Company Medicare Products
Part D Appeals and Grievances Department
P.O. Box 7773
London, KY 40742

sending a fax to 1 (800) 535-4047

Appeals should include:

- Your name and ID number.
- Specific information relating to and reason for the Appeal.
- Your expectation for resolution.
- Copies of medical records or other documentation that You wish to be considered in the Appeal.

All levels of the appeals process will be handled by individuals not involved in a previous determination. Appeals involving clinical issues will be reviewed by a practitioner in the same or a similar specialty that typically manages the medical condition, procedure or treatment in question.

You will be notified in writing within five (5) working days of receipt of the Appeal request. We will complete Our investigation and will notify You of the resolution within five (5) working days after the respective Appeal is completed. A decision on the first level Appeal will be made as quickly as the situation demands but in no event later than the time frames set forth below:

- **Urgent Care Claim - 36 hours**
- **Pre-Service Claim - 15 days**
- **Post-Service Claim - 20 working days**

If You are not satisfied with the outcome of the First Level Appeal, You have the right to initiate a final appeal. A Member or Authorized Representative has one hundred eighty (180) days from the date of receipt of the outcome of the First Level Appeal to file a final Appeal with the Plan.

The Second Level Appeal will be conducted by a panel selected by Us consisting of a health plan representative and other enrollees. In the case of Appeals based in whole or in part on medical judgment, the panel shall consist of a majority of qualified health care professionals who have appropriate training and experience in the field of medicine involved in the medical judgment.

A hearing will be convened during a reasonable time period so that the Second Level Appeal can be concluded within the time periods specified above. You or Your Authorized Representative will be notified in advance of the place, date and time of the hearing and of the right to receive, free of charge, reasonable access to and copies of documentation relevant to the Appeal. We will hold the Second Level Appeal hearing during regular business hours at a location reasonably accessible to You or Your Authorized Representative. Any supporting material may be submitted before and at the hearing. You may also be represented by a person of Your choice.

5.4 External Review Process

If You have exhausted the internal appeal process and are not satisfied with the decision of the Appeal Committee in Your appeal, You or Your Authorized Representative have the right to request an external review of an Adverse Benefit Determination within one-hundred eighty (180) days of the date of the final Adverse Benefit Determination. We will notify You in writing regarding a final Adverse Decision and of the opportunity to request an External Review.

5.5 Inquiries Generally

You have the right to file a complaint with your state's Department of Insurance at any time.

- **Arkansas Residents**: Arkansas Insurance Department, 1200 West Third St., Little Rock, AR 72201 or toll free 1-800-282-9134.
- **Kansas Residents**: Kansas Insurance Department, 420 SW 9th St., Topeka, KS 66612-1678 or toll free at 1-800-432-2484.
- **Missouri Residents**: Missouri Department of Insurance, P.O. Box 690, Jefferson City, MO 76102-0690 or toll-free at 1-800-726-7390.
- **Oklahoma Residents**: Oklahoma Department of Insurance, 3625 NW 56th , STE 100, Oklahoma City, OK 73112-4511 or toll free at 1-800-522-0071

5.6 ERISA Rights

As a participant or beneficiary of an employee welfare benefit plan under ERISA, Members may have the right to bring a civil action under ERISA Section 502(a). Members may exercise this right to recover coverage due under the Group Contract, enforce the Member's rights under the Group Contract, or to clarify rights to future coverage under the terms of the Group Contract. Members must exhaust the internal Appeal process before bringing a civil action under ERISA Section 502(a). Members of government or church-sponsored plans do not have this right.

ARTICLE VI - PARTICIPATING PHARMACIES

6.1 Participating Pharmacies. All Participating Health Care Pharmacies may collect Copayments from Members and must seek the remaining payment for Covered Drugs from the Plan. A Participating Pharmacy provider may seek payment from a Member for a non-covered service so long as the provider informs the Member prior to performing the non-covered service that the Member may be liable to pay for the same and the Member accepts such liability.

When obtaining Prescription Drugs at a Participating Retail Pharmacy You must:

A. Present Your ID card to the Participating Retail Pharmacy to receive coverage for Prescription Drugs.
B. Pay the following to a Participating Retail Pharmacy: One (1) Retail Copayment or the cost of the Prescription Drug, whichever is less, for each of the following: (i) one Prescription Order or Refill, or (ii) one unit (i.e., tube, box or container) of a commercially prepackaged drug, including but not limited to topicals, inhalers and vials.

6.2 Non-Participating Pharmacy. Generally, we cover Covered Drugs filled at an out-of-network pharmacy only when You are not able to use a Participating Pharmacy.

We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care, are included in our Formulary without restrictions, and otherwise qualify as Covered Drugs.

In these situations, you will have to pay the full cost (rather than paying just your copayment or coinsurance) when you fill your prescription. You can ask us to reimburse

You for Our share of the cost by submitting a paper claim form within three (3) months of the purchase of the drug. YOU WILL BE RESPONSIBLE FOR PAYING THE DIFFERENCE BETWEEN WHAT WE WOULD PAY FOR A PRESCRIPTION FILLED AT A PARTICIPATING PHARMACY (ELIGIBLE CHARGES) AND WHAT THE OUT-OF-NETWORK PHARMACY CHARGED FOR YOUR PRESCRIPTION.

We cannot pay for any prescriptions that are filled by pharmacies outside of the United States and territories, even for a medical emergency or urgently needed care.

Examples of special circumstances when you can use an out-of-network pharmacy include:

(i) If you are unable to get a covered drug in a timely manner because there is no network pharmacy within a reasonable driving distance providing 24-hour service.

(ii) If you are trying to fill a covered prescription drug that is not regularly stocked at a network retail or mail-order pharmacy (these drugs include orphan drugs or other specialty pharmaceuticals).

(iii) If you get a covered prescription drug from an institutional based pharmacy while a patient in an emergency room, provider based clinic, outpatient surgery clinic, or other outpatient setting.

(iv) If you become evacuated due to a state or federal emergency disaster declaration or other public health emergency declaration and cannot readily find an in-network pharmacy.

In these situations, please check first with Customer Service to see if there is a Participating Pharmacy nearby. If there is no network pharmacy nearby and you purchase your Covered Drugs at an out-of-network pharmacy, you will have to pay the full cost (rather than paying just your copayment or coinsurance) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form within three (3) months of the purchase of the drug. You will be responsible for paying the difference between what we would pay for a prescription filled at a Participating Pharmacy and what the out-of-network pharmacy charged for your prescription.]

6.3 Prior Authorization. IF A MEMBER USES A NON-PARTICIPATING HEALTH CARE PROVIDER, THE MEMBER MUST COMPLY WITH ALL OF THE PLAN'S PRIOR AUTHORIZATION REQUIREMENTS (discussed below). If the services or items requiring preauthorization are not arranged by a Participating Health Care Provider, the Member must contact the Plan for the preauthorization prior receiving the Prescription Drug, or; in the event of Emergency Services, as soon as reasonably possible.

6.4 Services. Health care providers, including, without limitation, Participating Pharmacies, are solely responsible for the services rendered to their patients.

ARTICLE VII – BENEFITS

7.1 THIS CERTIFICATE OF INSURANCE PROVIDES COVERAGE FOR COVERED DRUGS PROVIDED TO MEMBERS WHO QUALIFY FOR THE COVERAGE GAP DISCOUNT FOR SO LONG AS THE COVERAGE GAP DISCOUNT IS IN EFFECT.

7.2 Preauthorization Review. Some drugs require Prior Authorization in order for them to be Covered Drugs. These include but are not limited to medications that may require special medical tests before use, or that are not recommended as a first-line treatment, or that have a potential for misuse or abuse. Drugs requiring Prior Authorization are identified in the Drug Formulary with "PA" next to the name of the drug. Before You can fill a Prescription Order or Refill for a drug requiring Prior Authorization, the Prescriber must call Us.

7.3 Coverage. We will provide coverage under this Certificate of Insurance for Covered Drugs that qualify for the Coverage Gap Discount. The Coverage Gap Discount is the discount from Prescription Drug manufacturers that is offered as part of the Affordable Care Act for Medicare beneficiaries subject to the Coverage Gap (some times referred to as the "donut hole"). The Coverage Gap Discount is subject to the Out-of-Pocket Cost and is not available if Medicare is not the primary payer or You are receiving Extra Help (a Medicare program for people with limited income and resources to pay for prescription drug costs).

For so long as you qualify for the Coverage Gap Discount until you reach your Out-of-Pocket Cost, we will automatically apply the Coverage Gap Discount to your pharmacy claims. We will pay for your Covered Drugs while the Coverage Gap Discount is in effect and you will be responsible to pay Your Copayments listed below. The amount of Your Copayment is determined on the cost-sharing Tier for the Covered Drug. There are four (5) Tiers: Tier 1, Tier 2, Tier 3, Tier 4 and Tier 5. See the Drug Formulary to determine which Tier a particular Covered Drug is listed in.

If you have any questions about the availability of discounts for the drugs you are taking or about the Coverage Gap Discount in general, please contact Customer Service at the phone number on your ID Card.

Cost-Sharing Tier	Retail Pharmacy (30-day supply)	Retail Pharmacy (90-day supply)	Long-Term Care Pharmacy (31-day supply)	Mail-Order Pharmacy (30-day supply)	Mail-Order Pharmacy (90-day supply)
Tier 1: Preferred Generic Drugs at Network Pharmacy	**$5**	**$10**	**$5**	**$5**	**$10**
Tier 2: Non-	72% of the plan's costs	72% of the plan's costs	72% of the plan's costs	72% of the plan's costs	72% of the plan's costs

Preferred Generic Drugs	for generic drugs	for generic drugs	for generic drugs	for generic drugs	for generic drugs
Tier 3: Preferred Brand Drugs	47.5% for the plan's costs for brand drugs	47.5% for the plan's costs for brand drugs	47.5% for the plan's costs for brand drugs	47.5% for the plan's costs for brand drugs	47.5% for the plan's costs for brand drugs
Tier 4: Non-Preferred Brand	47.5% for the plan's costs for brand drugs	47.5% for the plan's costs for brand drugs	47.5% for the plan's costs for brand drugs	47.5% for the plan's costs for brand drugs	47.5% for the plan's costs for brand drugs
Tier 5: Specialty Drugs	72% of the plan's costs for generic drugs or 47.5% for the plan's costs for brand drugs	72% of the plan's costs for generic drugs or 47.5% for the plan's costs for brand drugs	72% of the plan's costs for generic drugs or 47.5% for the plan's costs for brand drugs	72% of the plan's costs for generic drugs or 47.5% for the plan's costs for brand drugs	72% of the plan's costs for generic drugs or 47.5% for the plan's costs for brand drugs

Coverage Gap
After your total yearly drug costs reach $2,850, you receive limited coverage by the plan on certain drugs. For Tier 1 the copayment above applies, for Tiers 2 -5, you will also receive a discount on brand name drugs and generally pay no more than 47.5% for the plan's costs for brand drugs and 72% of the plan's costs for generic drugs. Once your yearly out-of-pocket drug costs reach $4,550 your Catastrophic Coverage applies, *see your Summary of Benefits*.

Out-of-Network Coverage Gap
You will be reimbursed up to 28% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s).

You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s).

7.4 Pharmacies. Prescription Drugs are Covered Drugs at Participating Retail Pharmacies, Mail Order Pharmacies and at Non-Participating Retail Pharmacies in the amounts described below when they are: (i) Ordered by a Prescriber for use by a Member; and (ii) Not limited or excluded elsewhere in this Certificate of Insurance. A list of all network pharmacies is provided in our Pharmacy Directory and on Our website at http://coventry-medicare.coventryhealthcare.com/locate-a-provider/pharmacies/index.htm

7.5 General Quantity Limits. In general, the quantity of a Prescription Drug dispensed by a Retail Pharmacy for each Prescription Order or Refill for a non-Maintenance Drug is limited to the lesser of:

(i) The amount prescribed in the Prescription Order or Refill; or
(ii) The amount determined by Us to be Medically Necessary; or
(iii) The amount determined by Us to be up to a 31-day supply for non-maintenance drugs; or
(iv) The amount determined by Us to be up to a 90-day supply for maintenance drugs

Maintenance Drugs are covered when obtained through a Retail or Mail Order Pharmacy. The quantity of a Maintenance Drug for one Prescription Order or Refill limited to is a 30 or 90-day supply as long as the Prescription Drug is determined by Us to be Medically Necessary.

7.6 Specific Quantity Limits. Some medications are subject to specific quantity limits. You can get information on specific quantity limits from the searchable Drug Formulary on Our web site at

http://www.FHDFormulary.coventry-medicare.com or by contacting the Customer Service Department. Before You can fill a Prescription Order or Refill for a drug that exceeds the specific quantity limit, the Prescriber must contact Us.

7.7 Step Therapy. Step Therapy (ST) is an automated process of Prior Authorizing certain Drugs subject to Step Therapy guidelines. Step Therapy drugs are noted with an "ST" next to the name of the drug on the Drug Formulary. Step Therapy medications require prior use of one or more certain prerequisite medications as shown in the Member's medication history with Us. If the prerequisite medications are not present in the Member's medical history, the Prescriber must contact Us for Prior Authorization and payment before filling a Prescription Order or Refill for any drug requiring Step Therapy.

7.8 Travel Supply. When You will be traveling for an extended period of time, You are eligible to receive up to a 90-day supply of Prescription Drugs. To be approved for a 90-day supply for travel, contact Us at the telephone number listed on the back of Your ID card.

ARTICLE VIII – LIMITATIONS AND EXCLUSIONS

The services not expressly listed in Article VII or expressly excluded or limited in this Article VIII are excluded from coverage under this Certificate of Insurance.

The following limitations apply under this Certificate of Insurance:

8.1 Prescriptions Drugs that are not covered under Your Medicare Advantra Prescription Drug coverage (Part D), such as but not limited to Medicare Part B drugs, vitamins, cough and cold drugs, erectile dysfunction drugs, barbiturates or benzodiazepines.

8.2 Prescription Drugs that are not Medically Necessary.

8.3 Prescription drugs that are not authorized in accordance with the Plan's utilization management policies and procedures or that are not received in accordance with the terms and conditions of this Certificate of Insurance.

8.4 A pharmacy shall not dispense a Prescription Order or Refill which, in the pharmacist's professional judgment, should not be filled.

8.5 Authorized refills will be provided for the lesser of: (i) twelve (12) months from the original date on the Prescription Order unless limited by state or federal law; or (ii) the number of refills indicated by the Prescriber.

8.6 Some medications are subject to quantity limits. Specific quantity limits can be obtained through the Customer Service Department and Our searchable Drug Formulary on Our website.

8.7. We reserve the right to include only one manufacturer's product on Our Drug Formulary when the same or similar drug (that is, a drug with the same active ingredient), supply or equipment is made by two or more different manufacturers. The product that is listed on Our Drug Formulary will be covered at the applicable Copayment. The product or products not listed on Our Drug Formulary will be excluded from coverage.

8.8 We reserve the right to include only one dosage or form of a drug on Our Drug Formulary when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms (for example but not limitation, dissolvable tablets, capsules, etc.) from the same or different manufacturers. The product in the dosage or form that is listed on Our Drug Formulary will be covered at the applicable Copayment.

8.9 Prior Authorization is required for selected products with a Narrow Therapeutic Index, potential for misuse and/or abuse, and a narrow or limited range of FDA approved indications. These products may not be available from the Mail Order . Information about which drugs require Prior Authorization can be obtained through the Customer Service Department and Our searchable Drug Formulary on Our website.

8.10 Coverage through the Mail Order is not available for drugs that are not Maintenance Drugs as defined by Us, drugs that cannot be shipped by mail due to state or federal laws or regulations, or when We consider shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, all controlled substances, and anticoagulants.

8.11 We reserve the right to limit the location at which a Member can fill a covered Prescription Order or Refill to a pharmacy that is mutually agreeable to both Us and the Member. Such limitation may be enforced in the event that We identify an unusual pattern of claims for Covered Drugs.

8.12 Any Prescription Drugs, injectables, supplies, devices or other items covered and paid under your Medicare Advantra Prescription Drug coverage (Part D).

8.13 Devices or supplies of any type, even though requiring a Prescription Order. These include, but are not limited to therapeutic devices, support garments, corrective appliances, non-disposable hypodermic needles, or other devices, regardless of their intended use.

8.14 Drugs prescribed and administered in the Physician's office, or during, or as part of an inpatient or ambulatory surgery procedure or admission.

8.15 Implantable time-released medication, including, but not limited to implantable contraceptives.

8.16 Drugs which do not require a prescription by federal or state law, unless specifically designated for coverage by Us. For example but not limitation: over-the-counter drugs or

over-the-counter equivalents, behind-the-counter drugs, nutraceuticals, medical foods (except when coverage is required by law), and dietary supplements.

8.17 Drugs, oral or injectable, used for the primary purpose of, or in connection with, treating infertility, fertilization and/or artificial insemination.

8.18 Any prescription drugs which are, or the use of which is, Experimental or Investigational.

8.19 Drugs used for athletic performance enhancement or cosmetic purposes, including, but not limited to anabolic steroids, tretinoin for aging skin and minoxidil lotion.

8.20 Drugs and other products used primarily for smoking cessation.

8.21 Vitamins, both over-the-counter and legend.

8.22 Oral dental preparations and fluoride rinses, except fluoride tablets or drops.

8.23 Refill prescriptions resulting from loss.

8.24 Pharmacological therapy for weight reduction.

8.25 Prescriptions for which You are entitled to receive coverage without charge under any Workers' Compensation Law, or occupational disease statute, or any law or regulation.

8.26 Compound Prescriptions are excluded unless all active ingredients are Covered Drugs.

8.27 Non-Formulary Drugs unless approved by Us, including brand versions of formulary generic drugs.

8.28 Medications to prevent infections related to foreign travel are excluded from coverage

8.29 Medications used for the treatment or ongoing maintenance care of non-congenital transexualism, gender dysphoria, or sexual reassignment or change.

8.30 This Certificate of Insurance provides coverage for prescription drugs only. No services, supplies, therapeutic devices or equipment are covered under this Certificate of Insurance.

ARTICLE IX - BENEFIT INTEGRATION WITH OTHER COVERAGE

You are only eligible to receive coverage under this Certificate of Insurance if you are eligible to receive the Coverage Gap discount. This means that Medicare must be your primary payer. This Certificate of Insurance covers Covered Drugs not covered by your Advantra Medicare coverage but does not integrate benefits with any other coverage.

ARTICLE X - THIRD PARTY LIABILITY

Benefits related to injuries caused by an act or omission of a third party will be covered under this Certificate of Insurance. A Member who receives such benefits shall be required to reimburse the Plan for the cost of such benefits when the Member receives full compensation for his/her injury; provided, however, that the Member shall not be required to pay the Plan more than any amount recovered from the third party.

ARTICLE XI - ASSIGNMENT OF BENEFITS OR PAYMENTS

Members are not permitted to assign benefits or payments for services covered under this Certificate of Insurance. Further, Members are not permitted to assign their rights to receive payment or to bring an action to enforce this Certificate of Insurance, including, but not limited to, an action based upon a denial of benefits unless required by applicable law.

ARTICLE XII - REIMBURSEMENT FOR SERVICES RENDERED BY NON-PARTICIPATING PHARMACIES

12.1 When Notice of Claim is Required. Participating Pharmacies are responsible for submitting claims directly to the Plan for services, supplies, or equipment provided to Members. However, when a Member receives services, supplies or equipment from a Non-Participating Pharmacy, the Member must provide the Plan written notice of the claim within ninety (90) days . Claims forms can obtained by downloading a copy from our website: http://www.FHDFormulary.coventry-medicare.com or by contacting the Customer Service number on your identification card. Claims for services rendered by Non-Participating Pharmacy should be sent to the following mailing address,:

Express Scripts - Attn: Medicare Part D
PO Box 2858
Clinton, IA 52733-2858

12.2 Content and Time Limits on Claims Submissions (Proofs of Loss). If a charge is made to a Member for any service that is reimbursable under this Certificate of Insurance, written proof of such charge shall include an itemized statement and diagnosis and must be submitted to the Plan at the address above within ninety (90) days after the delivery of the service or as soon as reasonably possible, but in no event, except in the absence of legal capacity, later than one year after the date of service. Such services must have been provided in accordance with the Plan's utilization management and preauthorization policies and procedures. Failure to furnish such documentation within the specified period shall invalidate or reduce any such claim unless for good reason, as determined by the Plan, it was not possible to submit the claim within the specified period, provided such proof is produced in a timely basis.

ARTICLE XIII – MEMBER RECORDS

13.1 Confidentiality. Information from medical records of Members and information received by Participating or Non-Participating Health Care Providers incident to the physician-patient relationship shall be kept confidential as required by applicable state and federal law except that such information may be released by or to the Plan or its designee for the purposes of use incident to bona fide medical research and education, investigation of utilization or quality of care, or as reasonably necessary in connection with the administration of this Certificate of Insurance.

13.2 Records.

A. Contract Holder shall forward, in a timely manner, the information periodically required by the Plan in connection with the administration of the Group Contract. All records of the Contract Holder that have a bearing on the administration of the Group Contract shall be open for inspection by the Plan at any reasonable time.

B. The Plan shall not be liable for the fulfillment of any obligation dependent upon information that is required to be provided by the Contract Holder prior to receipt of the information in a form satisfactory to the Plan. In no event shall coverage be provided under the Group Contract due to clerical error or other action or omission incorrectly recording or reporting a Member for coverage when such Member is ineligible for such coverage according to the provisions of the Group Contract.

C. The Plan is entitled to receive from any provider of services, including, without limitation, Participating or Non-Participating Health Care Providers, any Member information reasonably necessary in connection with the administration of this Certificate of Insurance. By acceptance of coverage under this Certificate of Insurance, the Member authorizes any provider rendering services hereunder to disclose all facts pertaining to such care and treatment and physical condition of the Member to the Plan upon request, and to render reports pertaining to the same and to permit copying of records by the Plan.

ARTICLE XIV – GENERAL

14.1 The Group Contract shall constitute the entire contract between the parties. All statements in the absence of fraud pertaining to coverage under the Group Contract that are made by a Subscriber shall be deemed representations, but not warranties.

14.2 The Group Contract is not in lieu of and does not affect any requirement for coverage by Workers' Compensation Insurance.

14.3 No person other than a Member is entitled to receive health care service or other benefits to be furnished by the Plan under this Certificate of Insurance. Such right to health care services or other benefits is not transferable.

14.4 No change in the Group Contract shall be valid unless approved by an officer of the Plan and evidenced by endorsement on the Group Contract and/or by amendment to the Group Contract.

14.5 The relationship between the Plan and health care providers is that of an independent contractors. Health care providers are not agents or employees of the Plan, nor is the Plan or any employee of the Plan an employee or agent of health care providers.

Neither the Contract Holder nor any Member is an agent or representative of the Plan, and neither shall be liable for any acts or omissions of the Plan for the performance of services under the Group Contract.

14.6 Acceptance of the Group Contract will be indicated by Contract Holder: (i) compiling and furnishing a list of Members to the Plan; and (ii) submitting any applicable premiums to the Plan. Such acceptance renders all terms and conditions hereof binding on the Contract Holder, the Plan and any Members.

14.7 The Plan may amend the Group Contract, or any provision thereof, in accordance with applicable law, at any time on thirty (30) days prior written notice to the Contract Holder.

14.8 Any notice under the Group Contract shall be given by the United States mail, postage prepaid, addressed as follows:

i. If to Subscriber: to the latest address provided by the Subscriber on the Enrollment Application or Change of Address Forms actually delivered to the Plan.

ii. If to Contract Holder: to the latest address provided by the Contract Holder to the Plan.

iii. If to the Plan: 9401 Indian Creek Parkway Suite 1300, Overland Park, KS 66210.

14.9 The failure of either the Plan, the Contract Holder, or a Member to enforce any provision of the Group Contract shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of the Group Contract shall not be deemed or construed to be a waiver of such default.

14.10 Reservations and Alternatives - We reserve the right to contract with other corporations, associations, partnerships, or individuals for the furnishing and rendering of any of the services or benefits described herein.

14.11 Discounts and Rebates: Member understands and agrees that we may receive a retrospective discount or rebate from a Participating Health Care Provider or vendor related to the aggregate volume of services, supplies, equipment or pharmaceuticals purchased by persons enrolled in health care plans offered or administered by the Plan. Member shall not share in such retrospective volume-based discounts or rebates. However, such rebates will be considered, in the aggregate, in our prospective premium calculations

14.12 Policies and Procedures: We may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this Group Contract

14.13 Discretionary Authority We have the discretionary authority to interpret the Contract Holder's plan in order to make eligibility and benefit determinations. We also have the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under this Group Contract.

14.14 Each Member authorizes and directs any pharmacy that filled a Prescription Order or Refill covered under this Group Contract to make available to Us information relating to all Prescription Orders or Refills, copies thereof and other records as needed by the Us to implement and administer the terms of this Group Contract, conduct appropriate quality review or investigate possible substance abuse or criminal activity. Each Member, by accepting coverage under this Group Contract, agrees that the Plan and any of its designees shall have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Group Contract, conduct appropriate quality review or investigate possible substance abuse or criminal activity.

14.15 We shall not be liable for any claim, injury, demand or judgment based on tort or other grounds (including warranty of drugs) arising out of or in connection with the sale, compounding, dispensing, manufacturing, or use of any Prescription Drug.